



Children's Mental Health in Idaho

Summary Report 1980 to 2012

Idaho Department of Health and Welfare Division of Behavioral Health www.mentalhealth.idaho.gov



Executive Summary

This report is being prepared as a result of discussions during the Jeff D. meeting that took place on November 9, 2012, with plaintiffs' attorneys. Defendants were asked to provide a summary of the progress or status of the children's mental health program since the Jeff D. case began in 1980 to the present. In response to that request, this report has been prepared. It focuses on the progress of children's mental health from 1980 to November 2012, and it summarizes the major milestones and events that have impacted the children's mental health system of care.

Much has occurred during the 32 years that have transpired since the initial filing of the complaint, including important improvements that have been implemented since the dismissal of the case in 2007. This report provides a brief overview of some of the events and system changes that have occurred and how they are affecting the current transformation efforts. The report is merely a summary. It is by no means all inclusive or descriptive of every detail.

The Governor and the Department of Health and Welfare are committed to the ongoing transformation of the current behavioral health system for children and adults. The Department of Health and Welfare and the Legislature have been interested in behavioral health transformation for years. Advocates, consumers, families, providers, and agency staff have also looked for ways to improve the system. The current transformation efforts are intended to be a comprehensive approach to transforming both mental health and substance use treatment for children and adults. It must be emphasized that the time and effort being expended in the transformation are immeasurable. Fortunately, the transformation appears to have the political and public support needed to move forward.

The Jeff D. case and the ongoing evolution of children's mental health care have provided the foundation for a number of the improvements that have occurred during the past three decades as well as for the ongoing transformation. For example, system of care principles, such as individualized treatment, consumer and family involvement, interagency coordination, community-based services, community supports, evidenced-based practices, and an array of services are pervasive in the ongoing transformation efforts. The transformation of the whole system is possible largely due to the aforementioned foundation stemming from Jeff D.

Although positive momentum is carrying the transformation forward, this momentum may potentially be dampened if undue emphasis is placed on historical aspects of Jeff D. that are inconsistent with the current transformation. Although Jeff D. was crucial in establishing the foundation of the current system as well as the ongoing transformation, it is imperative that the transformation be allowed to be built on top of the Jeff D. foundation without unnecessary interference from the portions of Jeff D. that are obsolete, completed, or outdated, or that would be inequitable to apply prospectively. On the other hand, the aspects of Jeff D. that have been successfully implemented will continue to be an inherent ingredient in the current system and in the transformation. The key in this delicate balance is to retain the portions of Jeff D. that remain useful while avoid inhibiting or delaying the total transformation that is transpiring in behavioral health.

One of the purposes of this report is to allow the parties involved in Jeff D. to focus on the historical benefits stemming from three decades of Jeff D. that have become part of the fabric of the system in Idaho and to simultaneously seek a mutual recognition that Jeff D. is the foundation of the system rather than the entire structure of the system that has been built and that is being built on top of the foundation.



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Introduction

This report is being prepared by the Department of Health and Welfare in response to the November 9, 2012, meeting on the Jeff D. case with plaintiffs' attorneys. Plaintiffs' attorneys requested that Defendants review the progress or status of the children's mental health program since the Jeff D. case began. This report focuses on the progress of children's mental health from 1980 to November 2012. This report summarizes the major milestones and events that impact the children's mental health system of care.

Children with serious emotional disturbance (SED) and their families are served by various agencies and programs in the state of Idaho. Children with SED with Medicaid are served primarily in the private sector through Medicaid mental health providers. These children are on the Medicaid Enhanced Benchmark benefit plan which provides more services than the Basic Benchmark plan. Children identified in schools are served through school programs and services, some of which can be billed to Medicaid. The Department of Juvenile Corrections (DJC) provides the necessary services for children with SED committed to their custody. They have additional funding for children in the community under county supervision. The Department of Health and Welfare/Children's Mental Health (CMH) program provides services to those children with SED without other benefits who meet eligibility criteria and a service agreement (treatment plan) is negotiated with parents. The CMH program also serves children with SED under court order.

Background in 1980

Children with serious emotional disturbance were served through the Department of Health and Welfare's Division of Community Rehabilitation when the Jeff D. case arose in 1980. There was no separately identified "children's mental health program." The Division of Community Rehabilitation provided counseling services to both adults and children. Individuals committed to the state under civil procedures were placed in state-run psychiatric hospitals. Children in need of inpatient or residential care had to meet the involuntary commitment requirements of Idaho Code § 66-329. Voluntary admissions to the State Hospital were possible but the child still had to be mentally ill and dangerous to self or others. Little, if any, case management was provided to children and their families. Outpatient counseling was the main community-based service and was provided by staff of the Division of Community Rehabilitation.

The Department through a different Division provided child welfare services to abused and neglected children and services to juvenile offenders under the Youth Rehabilitation Act. Both programs provided residential care and foster care to youth in state custody. Mental health assessments and treatment were provided through Medicaid providers, DHW staff, or private providers under contract with DHW.

State Hospital South

A separate Adolescent Unit was established in 1984. This met many requirements found in the 1983 and 1990 consent decrees in Jeff D., in particular the separation of children from adults. The Adolescent Unit is a Medicaid eligible provider and bills Medicaid and other insurances for services for eligible children. Additionally, the hospital staff assist non-Medicaid eligible children to apply for Medicaid. Regional children's mental health (CMH) staff assist in the admission process and provide ongoing case management while the child is in the hospital. Monthly staffings are held in person or via phone with parents, child, regional staff and state hospital staff to discuss progress, discharge planning and follow up services.



Regional CMH Program

The Department of Health and Welfare (DHW) established regional children's mental health programs as part of the Division of Family and Community Services in 1989. This resulted in a specialized program separate from the adult mental health program and aligned with the child welfare program. Child welfare funds were used to pay personnel and treatment costs which utilized Federal funds such as IV-E and Social Services Block Grant combined with state general funds. State staff provided case management and counseling services to voluntary and involuntarily committed children and families. Contracts were used to provide residential care and other needed services using child welfare funds.

The CMH program remained closely aligned with the child welfare program through the 90s. The programs utilized the same budget, but were tracked separately through administrative processes and information systems. The 2005 budget bill for state fiscal year 2006 separated the CMH budget from the child welfare budget. This was the first year the budget was treated as separate and distinct from the child welfare budget in an appropriations bill. The legislature in 2006 for state fiscal year 2007 combined in the appropriations bill the CMH budget with the Adult Mental Health (AMH) budget, but kept two distinct budget units for the programs. The Department was reorganized in June 2006 by Governor Risch and the Division of Behavioral Health (Division) was established.

CMH program staff assisted child welfare staff in determining the appropriateness of residential placement of children in custody of the state through child protection. The CMH program paid for the residential care for children placed under both CMH voluntary placements and children under child welfare until fiscal year 2008. The legislature in the 2007 session for fiscal year 2008 transferred the residential funding from the CMH budget to the child welfare budget. This allowed the child welfare program to be financially responsible for the cost of residential care for children with behavioral and emotional issues committed to their custody

The CMH programs prior alignment with child welfare allowed the program to access federal IV-E funding. CMH staff used the child welfare federally mandated SACWIS (State Adoption and Child Welfare Information System) system for federal reporting purposes. The system is called FOCUS (Family Oriented Community Users System). A time study revealed that CMH staff spent around 37% of their time in FOCUS documentation. The split in the budget also revealed the ongoing maintenance and system improvement costs for FOCUS. Children served by CMH in residential or foster care that were IV-E eligible revealed a penetration rate of approximately 15%. A financial and program analysis of these ongoing costs and benefits associated with IV-E revealed it was not a financial gain or a programmatic improvement for the CMH program. The child welfare program gained additional IV-E funding when the CMH program separated from the child welfare program in IV-E administrative claims. The loss of IV-E funding to the CMH program was offset by a transfer from child welfare of state general funds in the appropriations bill for fiscal year 2011.

The CMH program continues to access social service block grant, Medicaid fee for services, and Medicaid administrative funds.

The Department applied for and was awarded a Federal Children's Mental Health System of Care Cooperative Agreement from 2002 to 2008. This was a statewide cooperative agreement and supported the implementation and infra-structure development of a system of care as outlined in the 1999 Needs Assessment. The Cooperative Agreement supported the state and regional/community councils, training, wrap around, parent and child involvement, anti-stigma, and interagency coordination. The wrap around model, curriculum and training continues to be utilized as well as anti-stigma materials.

The CMH program serves children under court order either through involuntary proceedings under the Children's Mental Health Services Act (CMHSA) or under section 20-511A of the Juvenile Corrections Act. There are very few involuntary proceedings under the CMHSA. The legislature passed the statute amending the Juvenile Corrections Act and



establishing a new section, 20-511A, which allows a judge in a juvenile corrections or child protection proceeding to order DHW to conduct a mental health assessment and plan of treatment for a child. The plan of treatment can then be ordered by the court with DHW responsible for the cost of the treatment. CMH staff are actively engaged in this process throughout the state and participate in the court ordered screening teams that also supply the court with recommendations. There has been an increase in this program both in cost and number served since it was enacted in 2005. The Department has continued to monitor the cost and utilization and is working with the Supreme Court on improving the processes and outcomes for this program.

The Children's Mental Health Services Act

The Children's Mental Health Services Act (CMHSA) was passed by the Idaho Legislature in 1997 with an effective date of July 1, 1998. This Act essentially did away with the commitment of minors under the involuntary proceedings of Idaho Code Section 66-329. The CMHSA incorporates many of the system of care principles in its language and intent. Idaho Code Section 16-2402, Legislative Purposes, supports the concept of individualized services, supporting families to care for their child in their home, family involvement in treatment, least restrictive alternative principles, interagency coordination and collaboration, efficient and effective use of resources, community involvement, and no transfer of custody is required to receive services. Access to services is voluntary whenever informed consent can be obtained, the child meets the Department's eligibility criteria, and a written agreement is developed between the parents and the Department (Idaho Code Section 16-2406). Although there is a process for involuntary treatment in the act, it is seldom used and, when it is, parental involvement is still sought and custody is not transferred to the state.

The CMH program does not require that all children with SED be served through the CMH program. Consistent with Idaho Code Section 16-2402(4)(a) and 16-2406(1)(c) parents with Medicaid, insurance, or their own financial resources may access any provider of their choice.

1999 Needs Assessment

The Needs Assessment and subsequent 2001 Court Plan guided the system development for a period of time. There were five categories with recommendations under each category for improving the system of care. The categories are Parents, Collaboration, Management, Financing, Program Development, and Accountability. Each category will be addressed below.

Parents

The Needs Assessment promoted the participation of parents in all levels of the system.

The Department supported the development of a family run organization in 1998. Contracts have been in place with the family run organization, the Idaho Federation of Families for Children's Mental Health (IFFCMH), since that time. The contracts are supported with Federal Mental Health Block Grant funds and have been supplemented with state or Cooperative Agreement funds over the years. A major portion of the children's funding from the Block Grant has been set aside to support a family run organization contract to provide parental support and advocacy since 2000. This provides a consistent and steady funding stream for family support and advocacy services. The current contract with the IFFCMH requires that they are a family run organization with a majority of their board members being someone who has cared for a child with a behavioral or emotional disorder. The services under the contract include parent and child education and support to be better consumers of services and self advocates; anti-stigma activities; respite care provider recruitment and training; and reimbursement to families authorized to receive respite care by CMH.



The IFFCMH was designated by the state mental health planning council as the organization that would recommend parents for planning council membership. This responsibility was from 1999 to 2007 when Idaho Code was changed to reflect membership of parents on the planning council and the appointing authority was changed to the Governor (Idaho Code Section 39-3125). Parents were specifically identified as members of the regional mental health boards when Section 39-3130 was amended in 2009. The proposed transformation efforts continue to have parental involvement in the regional behavioral health boards and State Planning Council.

Consistent with the CMHSA, parents have a choice in the provider they use for services. Parents of children with SED are not required to go through the CMH program to access community based or community inpatient care for their child. They are required to work with the CMH program for access to inpatient care at the Adolescent Unit of State Hospital South or to access Department paid services. Families with Medicaid may access any willing Medicaid provider for needed services. (Idaho Code Section 16-2406(1)(c))

Parental involvement in the assessment and treatment planning process is standard practice for the CMH program and part of the requirements of the Medicaid managed care RFP (also called the Idaho Behavioral Health Plan). The CMH quality assurance case review process looks at the inclusion and participation of parents in services provided by CMH. Parents are informed of their rights and responsibilities when applying for services and the quality assurance case review process checks to see if this occurred.

The Division uses a family and consumer satisfaction survey for both children and adults. This survey is modeled after the national survey previously used by the federal Substance Abuse Mental Health Services Administration (SAMHSA). The Division has automated the survey and can be accessed through the internet. The Department has computer kiosks in each office and families may access the survey when in the office. Paper versions are also made available for those without internet access. Families are asked to complete the survey once a year and upon completion of services.

Collaboration

The Needs Assessment promoted interagency collaboration at the state and local level.

The state level and regional/local councils were established but met with limited success. The lessons learned from these councils are being utilized in the upcoming transformation efforts. The regional mental health boards will be established in statute and will have specific authorities and duties. Membership will include parents, school districts, local juvenile justice, community mental health providers, consumers, and DHW.

There have been several state level groups looking at behavioral health services for adults and children over the last few years. The Legislature established a Mental Health and Substance Abuse Treatment Delivery Systems Interim Committee to study behavioral health services in 2006. The final recommendations included support for judges to order community based treatment, report from Medicaid on funding treatment foster care, residential care, respite, family support, and services for children in detention, an additional in-depth study of the system by the legislature, and the concept of a regionally based behavioral health system.

The 2007 Legislative Health Care Task Force established a Mental Health Subcommittee. Additionally, funding was provided to conduct the in-depth study of the behavioral health system as recommended by the 2006 Interim Committee. The study was conducted by the Western Interstate Commission for Higher Education (WICHE). This study became known as the WICHE report and was presented to the 2008 Interim Committee and published in August 2008. Some of the recommendations include continued transformation of the system, the creation of regional behavioral health authorities, and establishing a statewide, prioritized package of services.

The Governor established the Behavioral Health Transformation Workgroup by Executive Order in 2009 and 2010 in response to the WICHE report. The final report from the Behavioral Health Transformation Workgroup recommended the



establishment of an office of transformation, regional boards, an interagency cooperative, support for DHW as the state mental health authority, and a defined base of core services. In 2011 the Governor established the Behavioral Health Interagency Cooperative by Executive Order. The Behavioral Health Interagency Cooperative is leading the current transformation efforts.

CMH convened the Juvenile Justice Children's Mental Health Workgroup (JJ/CMH) in 2005. This workgroup was necessary to focus on specific concerns for children with mental health issues in the juvenile justice system and the failure of the CMH councils to adequately address the issues. The workgroup has members from county juvenile justice, county detention facilities, the Idaho Supreme Court, State Hospital South Adolescent Unit including the psychiatrist, Medicaid, IFFCMH, parents, CMH, providers, and DJC. The workgroup has continued to meet and utilizes a professional facilitator. This workgroup is responsible for several system improvements and continues to work on issues in the juvenile justice arena. System improvement outcomes include the clinicians in the detention centers project, the appropriation of specific mental health funding for children involved in the juvenile justice system requested by DHW but appropriated to DJC, support for youth mental health courts, support for and training on strengths-based assessment and planning, ongoing training for wrap around, development of and concurrence on a common mental health assessment, development of and support for family involvement, and review of the 20-511A process to develop training and standards for its application.

Management

The Needs Assessment targeted several management issues such as collaboration, development of local councils, alternatives for commitment of children to DJC, management information improvements, improvements to Medicaid, and the use of video-conferencing.

Interagency collaboration and local councils were addressed in the Collaboration section above. The Department of Juvenile Corrections, the courts and CMH are addressing the issue of alternatives to commitment through Idaho Juvenile Rule 19. This court rule was modified to mandate a screening team composed of county juvenile justice, DJC, DHW, parents, and others as necessary to review alternatives to commitment. The CMH program takes the lead as the DHW representative and invites other DHW programs such as child welfare and developmental disabilities when needed. Information from DJC indicates the Rule 19 process is successful in diverting children from commitment.

The CMH program is able to track services and costs through its information system. The Medicaid program is able to track services and costs through its information system. The Medicaid managed care RFP is intended to bring greater efficiencies, effectiveness, and coordination of services.

Video conferencing is being and has been utilized across the state. Video conferencing equipment is available in nearly every office of DHW. It has been used for training, management meetings, case staffing, quality assurance, and by psychiatrists meeting with individual children and their families. The allowance and use of telehealth technology is also allowed and encouraged in the Medicaid managed care RFP. Medicaid currently has billing codes that support and allow video-conferencing in the delivery of services.

Financing

The Needs Assessment financing section focused on better use of Medicaid, IV-E, increasing the state budget for CMH, and financing for local communities.

The Medicaid managed care contract is designed to bring more efficiency and effectiveness to the delivery of mental health services. The CMH program recently revised the Random Moment Time Study (RMTS) to capture Medicaid administrative costs and Social Service Block Grant costs as part of the federally approved cost allocation plan. See the Regional CMH Program section above for the information on the CMH program and IV-E.



Children in DJC custody and placed in eligible facilities are qualified for Medicaid. Children placed in eligible facilities under the CMH program also qualify for Medicaid. Children in custody and placement of the child welfare program may also qualify for IV-E and qualify for Medicaid.

Schools have continued to utilize school based Medicaid billable services.

The CMH program budget has increased since the Needs Assessment. The funding identified in 1999 was \$2.9 million. The 2013 appropriation just for the CMH program is over \$12 million. This \$12 million does not include Medicaid paid services delivered by private providers.

Program Development

The Needs Assessment focused on the establishment of community services, limiting of expensive services, and increasing child mental health expertise in the local communities.

The system as a whole has increased community services. Service data from CMH, Medicaid, and DJC show an increase use of community based services.

Clinicians in CMH with at least a masters degree conduct standardized mental health assessments. They also use the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child and Adolescent Level of Care Utilization System (CALOCUS) when conducting the assessment and at periodic intervals thereafter. The CAFAS is used as an outcome measure over time.

The Governor's Behavioral Health Transformation Workgroup identified core services that are consistent with the CMH program's core services. The current transformation efforts focus on identifying who is responsible for the various services. Communities through their regional boards will be responsible for developing support services. Payers of services, such as Medicaid through the managed care contract, will be responsible for treatment services. The Division will continue as the safety net provider for children with SED and be responsible for treatment services for those children with SED without other benefits.

The CMH staff, courts, and DJC have worked diligently to come up with alternatives to higher cost placements. The utilization of residential care has decreased in the CMH program. DJC commitments have declined over the years. Efforts through Rule 19 and 20-511A have diverted children from more restrictive placements. The one area that is not controlled by CMH is the placement of children in community psychiatric hospitals paid by Medicaid. Parents may place a child in a community psychiatric facility if the child meets the necessary criteria. Medicaid conducts two retrospective reviews of the placement. One review is of the medical necessity of the placement and the second is a determination that less restrictive alternatives were not available.

Idaho is a mental health care professional shortage area. Some of the Department's offices have qualified as sites for the National Health Service Corps. In spite of being a mental health care professional shortage area, the Division has psychiatric services available in each region. Additional mental health expertise is accessed through contracts with community providers or through consultation and telehealth services from other areas of the state. The adolescent psychiatrist at State Hospital South also serves children in the DJC facility in St. Anthony and children in DHW's Region VI. The Medicaid managed care contract requires a network of qualified professionals throughout the state and is required to provide ongoing training of the network providers.



Accountability

The Needs Assessment focused on quality improvement, outcomes, reporting, and improving data systems.

The CMH program has been utilizing a case specific review tool as part of its quality assurance process. The reviews on CMH cases are conducted twice a year in each region using a randomized sample of cases. Areas reviewed include parent involvement, treatment planning, appropriateness and effectiveness of services, and compliance with rules and policies. The results of the reviews are discussed with the regions and a regional corrective action plan is developed to address the issues identified in the review.

The Juvenile Justice Children's Mental Health Workgroup functions as part of a quality improvement process. Issues that negatively and positively impact the system are discussed, analyzed, and reviewed. The work and recommendations of this group have been a direct result of this process. Clinicians in detention centers, specific mental health funding, family engagement, strengths based training, and the most recent work on improving the 20-511A process are a direct result of issues identified and analyzed by this group.

The Medicaid managed care contract requires the specification of outcomes, monitoring, and quality improvement as part of the contract.

The CMH program uses the CAFAS as an outcome measure for all children served. Utilization data on the CMH program is updated monthly on the DHW internet website and reported annually in the Department's Facts, Figures and Trends. Internally, the Division has a monthly dashboard of regional and statewide data on utilization, worker activity, and program enrollment. The Parenting with Love and Limits program provides ongoing evaluation and an annual report. An annual report regarding CMH and AMH programs and services is produced for the Federal Mental Health Block Grant and reviewed by the State Planning Council on Mental Health.

Quarterly and annual reports are prepared by DJC.

The State Planning Council prepares and submits an annual report to the Governor and Legislature on the strengths and weaknesses of the mental health system and makes recommendations on improving the system.

The CMH program has been utilizing the Web Infrastructure for Treatment Services (WITS) as the electronic health record since July 1, 2011. As noted in the "Regional CMH Program" section, staff spent nearly 37% of their time documenting in the prior data system. Documentation in WITS now only takes 20% of staff time. The Adult Mental Health and Substance Use Services program also use WITS. This provides one data system for the Division. WITS has been designated by the Centers for Medicare & Medicaid Services (CMS) as a meaningful use certified electronic health record. The Department continues to work on a data warehouse to link the other programs relevant data. The data warehouse currently has all of the prior CMH data from the FOCUS system.

Current Direction

The Governor and the Department are committed to transforming the current behavioral health system for children and adults. It is intended to be a comprehensive approach transforming both mental health and substance use services for children and adults. The Governor's Behavioral Health Interagency Collaborative has set the direction for transformation. The Division is moving forward with plans to implement the transformation. Many of the transformation efforts address the historical inadequacies of the system and build upon system of care principles under the categories identified in the 1999 Needs Assessment.



Parents

Parents are included in all levels of the transformation efforts. Current Idaho statutes provide for their membership on the State Planning Council and regional advisory boards and statute changes necessary for transformation will continue their involvement at those levels. Parent driven care is part of Medicaid managed care and services provided by the CMH program. This provides parental input and participation at the individual service delivery level. The Department is committed to and intends to continue to use Federal Block Grant funds for a family run organization to provide family and youth support, education, and advocacy.

Collaboration

Collaboration is occurring and will be enhanced through the transformation of regional boards. Collaboration will continue through current efforts of the Behavioral Health Interagency Collaborative and the JJ/CMH. The Medicaid managed care contractor will be required to collaborate with others such as the regional boards, advocacy organizations, courts, and the Division of Behavioral Health. The regional mental health boards will be established in statute and will have specific authorities and duties. Membership will include parents, school districts, local juvenile justice, community mental health providers, consumers, and DHW.

Management

Management and designated responsibilities within the system will be clearly defined and monitored through the regional boards, State Planning Council, and the Division of Behavioral Health as the behavioral health authority. Statute changes are proposed to set this structure in place. Current statute and rule allow for courts to consider mental health treatment and community based alternatives for children as risk of commitment to DJC. Medicaid is improving the management and oversight of behavioral health services through the managed care contract. The Division is using an electronic health record system for documenting the delivery of CMH services.

Financing

This area continues to be one in which future improvements can and will be made. The Medicaid managed care contract is one such area of improvement and efficiency for treatment services. The CMH program could contract with managed care network providers for treatment services for children without other benefits or until benefits can be secured. Funding for regional boards and the development of local community supports is being identified. Transformation will clearly identify responsibilities and the funding that can be used to support those responsibilities. For example, funding for respite care and family support services can be contracted from the CMH program to regional boards for the development and use of those services.

Program Development

Core services have been identified as well as defined in the transformation efforts and the responsibilities for the development and maintenance of the services are articulated in the transformation plans. Regional boards play a key role in the development of support services within their communities. Treatment services will be primarily provided through the Medicaid managed care network. This will provide statewide consistency and accountability. The Division as the behavioral health authority will provide oversight and standards for services as well as services to those without other benefits.

Accountability

Medicaid Managed Care is intended to improve utilization, efficiency and costs. This effort is the direct result of legislation passed by the Idaho Legislature mandating a managed care approach. The contract is anticipated to be awarded in early



2013 with service implementation scheduled to begin 180 days after the execution date of the contract. The contractor is required to have a quality improvement program that looks at treatment outcomes, performance standards, practice quidelines and a performance improvement process for identified deficiencies. The Division, as the behavioral health authority, will have a role in establishing standards and conducting quality assurance reviews for the system.

The transformation efforts have a high degree of accountability and visibility. The Legislature and the Governor have been committed to improving the system. Advocates have long sought improvements in the system. A plan for transformation is being advanced and is supported by the Department of Health and Welfare. Legislation is being proposed for the upcoming session that will facilitate the transformation. Medicaid managed care was pushed by the Legislature as a method to increase efficiency and effectiveness. The transformation of the behavioral health system appears to have the political support necessary to make the desired changes at this time. Additional planning efforts and alternatives stemming from an undue focus on Jeff D. will only delay the transformation and potentially derail the path that has been established for that transformation.